EXHIBIT 6

CIOX Health
P.O. Box 409740
Atlanta, Georgia 30384-9740
Fed Tax ID 58 - 2659941
(800) 367 - 1500

CIOX HEALTH
INVOICE

Invoice #: 0209791467
Date: 2/7/2017
Customer #: 1647625

Ship to:	Bill to:	Records from:
ERIN K BRADLEY WOLFF ARDIS ATTYS AT LAW 5810 SHELBY OAKS DR MEMPHIS, TN 38134-7315	ERIN K BRADLEY WOLFF ARDIS ATTYS AT LAW 5810 SHELBY OAKS DR MEMPHIS, TN 38134-7315	REGIONAL HOSPITAL OF JACKSON 367 HOSPITAL BLVD JACKSON, TN 38305-2080

Requested By: WOLFF ARDIS ATTYS AT LAW **DOB:** [redacted]
Patient Name: [redacted]

Description	Quantity	Unit Price	Amount
Reproduction Fee-Paper 0.07 per page			4.27
Mailing Supplies			0.32
Supplies	61	0.05	3.05
Shipping			3.29
Subtotal			10.93
Sales Tax			1.07
Invoice Total			12.00
Balance Due			12.00

Pay your invoice online at www.healthportpay.com

Terms: Net 30 days

Please remit this amount : $ 12.00 (USD)

CIOX Health
P.O. Box 409740
Atlanta, Georgia 30384-9740
Fed Tax ID 58 - 2659941
(800) 367 - 1500

Invoice #: **0209791467**

Check # _____

Payment Amount $_____

Please return stub with payment.

Please include invoice number on check.
To pay invoice online, please go to www.healthportpay.com or call (800) 367 1500.
Email questions to Collections@CIOXHealth.com.

(901) 202-4003
TELECOPIER:
(901) 763-3376

WOLFF ARDIS, P.C.
ATTORNEYS AT LAW
5810 SHELBY OAKS DRIVE
MEMPHIS, TENNESSEE 38134

Of Counsel:
Apperson Crump PLC

January 30, 2017

VIA FAX: 731-661-2196
Medical Records Department
Tennova McNairy Regional Healthcare Hospital
705 East Poplar Ave.
Selmer, TN 38375

NAME: [redacted]
DOB:
SSN: XXX-XX-0896

DATES OF RECORDS REQUESTED: 07/03/2015 to Present

Dear Sir or Madam:

Attached hereto please find an executed medical authorization allowing our office to obtain medical records and bills for treatment provided to Ms. [redacted]

We would appreciate your furnishing to us **any and all XRays, bills, and associated records** in your possession pertaining to the care and treatment of this patient, as well as executing the enclosed Affidavit verifying sad records are those maintained in the ordinary course of your business.

I appreciate your assistance and cooperation in this matter and look forward to receiving this information from you in the immediate future. Should you have any questions concerning any of the above, please do not hesitate to contact me on my direct line at 901-202-4003 or via email at ebradley@wolffardis.com. Thank you again for your help.

Sincerely,

Erin K. Bradley,
Paralegal

/ekb
Enclosures as stated

Certified # 7012 3090 0001 2420 4899

[redacted]

RECEIVED JAN 30 2017

[redacted]

HITECH AND HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.524(c)(4)(I) & 164.508

TO: Tennova McNairy Regional Healthcare Hospital
Name of Healthcare Provider/ Physician. Facility/ Medicare Contractor

705 East Poplar Ave.
Street Address
Selmer, TN 38375
City, State and Zip Code

RE: Patient Name: [redacted]
Date of Birth:
Social Security Number:

ATTENTION: This is request under the HITECH Act to provide my attorneys with my medical records in electronic format. If you are subject to the HITECH Act, you are prohibited under federal law from billing me or my attorneys for paper copies when an electronic copy has been requested. Federal law provides statutory penalties up to $1.5 million for willful and repeated violations of the HITECH Act. *This request applies to any business associate/ third-part vendor you hire to provide me and my attorneys with copies of my medical records.* Please contact my attorneys (901) 763-3336 if you have questions or concerns about this request.

RELEASE TO:

Wolff Ardis, P.C.
5810 Shelby Oaks Drive
Memphis, TN 38134
901.763.3336 (Phone)
901.763.3376 (Fax)

☑ I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HITECH and HIPAA identified above disclose full and complete protected medical information including the following:

☑ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/ histories, correspondence,

photographs, videotapes, telephone messages, and records received by other medical providers.

☑ All physical, occupational and rehab requests, consultations and progress notes.

☑ All disability, Medicaid or Medicare records including claim forms and record of denial of benefits.

☑ All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including X-Rays, CT scan, MRI, MRA, EMG, Fluoroscopy, bone can, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results; whether in video/ CDs/ films/ reels and reports.

☑ All pharmacy/ prescription records including NDC numbers and drug information handouts/ monographs.

☑ All billing records including all statements, insurance claim forms, itemized bills, and records of billing to third party payers and payment or denial of benefits for the period 7/3/2015 through present.

I understand the information to be released or disclosed may including information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), mental health, alcohol and drug abuse, sickle cell anemia, and genetic information. I authorize the release or disclosure of this type of information.

This protected health information is disclosed for the following purposes: At the request of the individual patient.

This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

You are authorized to release my requested records to Wolff Ardis, P.C. My lawyers agree to pay reasonable charges made by you to supply electronic copies of such records. You are directed to deliver all medical records – including radiographic studies – in electronic format, unless such records are not readily producible in electronic format. I understand that copies of radiographic studies I have requested will be billed at reasonable cost of reproducing those studies, if they are not available in electronic format.

I understand the following: See CFR §164.50(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of this authorization authorizes you to release the records I am requesting be sent to my attorneys. This authorization will expire two years from the date signed below.

Jennifer Monroe — 1-30-17
Signature of Patient or Legally Authorized Representative — Date

Jennifer Monroe, mother of [redacted]
Name and Relationship of Legal Authorized Representative to Patient

[signature] — 1/30/2017
Witness Signature — Date

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
EASTERN DIVISION

[redacted]

Plaintiff,

v.

[redacted]

JURY DEMAND

[redacted]

Defendant.

AFFIDAVIT OF CUSTODIAN OF RECORDS

STATE OF _____

COUNTY OF _____

I, Baleri Cunningham, am the duly authorized Custodian of Records of ~~Tennova Healthcare~~ Regional Jackson and as such have the authority to certify the attached records. The records attached hereto constitute a true and correct copy of the medical records pertaining to the treatment provided to [redacted] The attached records were prepared by the personnel of THRJ at or near the time of the act, condition or event reported in the records. These records are kept in the course of the regularly conducted business of this office.

CUSTODIAN OF RECORDS

SWORN TO AND SUBSCRIBED before me this 31st day of January, 2017.

SHANIKA N SMITH
STATE OF TENNESSEE NOTARY PUBLIC
MADISON COUNTY
MY COMMISSION EXPIRES NOVEMBER 20, 2018

Shanika N. Smith
NOTARY PUBLIC

My Commission Expires: November 20, 2018

WOLFF ARDIS, P.C.
ATTORNEYS AT LAW

5810 SHELBY OAKS DRIVE
MEMPHIS, TENNESSEE 38134

(901) 763-3336
(901) 763-3376 (FAX)

FACSIMILE TRANSMISSION

TO: Medical Records Dept FAX NO: 731-661-2196
FROM: Erin Bradley DATE: Jan 30, 2017
TOTAL PGS (W/coversheet): 6 FILE NO.: 139913.0010

CALL (901) 763-3336 IF TRANSMISSION IS INCOMPLETE

TO TRANSMIT TO WOLFF ARDIS, P.C., FAX (901) 763-3376